Health Resource Allocation Plan Certificate of Need Process:

Technical Advisory Committee
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CON – What do you want it to be?

- Look at the Vermont experience
- Consider history nationally
- Discuss what CON can and can't do:
  - Cost control: where and how much
  - Public oversight
  - Linkages with other stakeholders and regulators
  - Part of broad planning effort

Key Questions

- Jurisdictional:
  - Facilities
  - Programs
  - Equipment
  - Thresholds
  - Exemptions
  - Past vs. future

More Questions

- Structure:
  - Scope
    - Cases, policies, initiatives, or combination
  - The Rules
    - What do you want it to be?
  - Resources
    - Staff, consultants, data,….

Still More Questions

- Consequences:
  - Intended:
    - Cost?
    - Quality?
    - Access?
    - Other?
  - Unintended:

Some Philosophy

- Never try to teach a pig to sing.
- You can’t get there in a car without wheels.
- "If you don't know where you are going, you will wind up somewhere else." (Yogi Berra)

Certificate of Need (CON)

- The purpose of the Certificate of Need (CON) program is to implement the public policy of this State such that **the general welfare and protection of the lives, health and property of the people of this State require that all new health care projects be offered or developed in a manner that avoids unnecessary duplication and contains or reduces increases in the cost of delivering services, while at the same time maintaining and improving the quality of and access to health care services, and promoting rational allocation** of health care resources in the State; **and that the need, cost, type, level, quality, and feasibility** of providing any new health care project **be subject to review** and assessment **prior to any offering or development**. See 18 V.S.A. §§9401, 9405, 9431.

The Law

18 V.S.A. § 9434. Certificate of need; general rules

- § 9434. Certificate of need; general rules
- (a) A health care facility other than a hospital shall not develop, or have developed on its behalf a new health care project without issuance of a certificate of need by the commissioner. For purposes of this subsection, a "new health care project" includes the following:
- …

- construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a health care facility ($1.5M or $3M threshold)

  change from one licensing period to the next in the number of licensed beds of a health care facility through addition or conversion, or through relocation from one physical facility or site to another.

  The offering of any home health service, or the transfer or conveyance of more than a 50 percent ownership interest of a home health agency

- For projects anticipated to be in excess of $20,000,000.00, the applicant first shall secure a conceptual development phase certificate of need, which permits the applicant to make expenditures for architectural services, engineering design services, and any other planning services needed in connection with the project.
- Upon completion of the conceptual development phase of the project, and before offering or further developing the project, the applicant shall secure a final certificate of need, in accordance with the standards and procedures established in this subchapter.

- The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00.

  (no un-bundling allowed)

The offering of a health care service or technology having an annual operating expense which exceeds $500,000.00 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed by the health care facility within the previous three fiscal years.

- “gap” jurisdiction between $750,000.00 and $1M if Commissioner finds that the proposed development:
- (1) may be inconsistent with the health resource allocation plan;
- (2) has the potential for significantly increasing utilization or rates; or
- (3) may substantially change the type, scope, or volume of service.

for hospitals the equipment threshold is $1m, no “gap” jurisdiction presently.

(can not un-bundle projects)

Same “new services” threshold ($500K operating expense)

CON CRITERIA

- (1) the application is consistent with the health resource allocation plan;
- (2) the cost of the project is reasonable, because:
  - (A) the applicant's financial condition will sustain any financial burden likely to result from completion of the project;
  - (B) the project will not result in an undue increase in the costs of medical care; and
  - (C) less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate;
- (3) there is an identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide;

CON CRITERIA

- (4) the project will improve the quality of health care in the state or provide greater access to health care for Vermont's residents, or both;
- (5) the project will not have an undue adverse impact on any other existing services provided by the applicant;
- (6) the project will serve the public good; and
- (7) if the application is for the purchase or lease of new health care information technology, it conforms with the health information technology plan established under section 9417 of this title, upon approval of the plan by the general assembly.

Act 53 Reforms

- Health Resource Allocation Plan
- Hospital Community Reports
- Billback for consulting needs in reviews
- Under oath/Criminal penalties
- Community Needs Assessments
- Linkage to State Health Plan
- Linkage to bonding agency

What Is the Health Resource Allocation Plan (HRAP)?

The HRAP, adopted by the Governor August 2, 2005, is a four-year plan that identifies (1) Vermont's **needs** in health care services, programs and facilities, (2) the **resources available** to meet those needs, and (3) the **priorities** for addressing those needs on a statewide basis.

*Act 53 specifies that the HRAP must include hospital, nursing home and other **inpatient services**; **home health and mental health services**; treatment and prevention services for **alcohol and other drug abuse**; **emergency care**; **ambulatory care** services, including primary care resources, federally qualified health centers, and free clinics; **major medical equipment**; and health **screening** and **early intervention** services.*

How Was the HRAP Developed?

The HRAP was developed with input from:

- The 13-member **HRAP Advisory Committee** (February 2004 - July 2005)

-The **hospital community needs assessments**

-The **state health plan**

-The **public** via hearings and other solicitations for feedback

- Industry **experts**

7 Overarching Themes

1. **Demographics of Aging**
   - pressuring limited resources.
   - Vermont's age 65 and older population is projected to **increase almost 50%** from 2000 to 2015 to be 17.5% of the total by 2015.
2. **Chronic Illness**
   - Care for people with chronic conditions in Vermont accounts for **78% of health care spending**
   - A 2004 RAND report indicates that more than **50% of people with several chronic diseases are not managed adequately** in the health care system.
   - There is a need for more **effective care**, **education** to support self-management, and **prevention** efforts.

3. **Prevention Services and Activities**
   - Continuous **HRAP Advisory Committee** theme
   - Health care delivery systems including provider **reimbursement** are designed around taking care of those that are ill. Prevention services and activities change this focus...
   - *"The success of prevention has been well documented in the areas of immunization, sanitation, workplace safety and dental disease, among others. We have been far less successful in preventing* ***chronic disease****..."* (State Health Plan)
4. **Workforce**
   - At the same time that demand is increasing,Vermont is experiencing workforce shortages and **mal-distribution**.
   - Most notably are **nursing**, **primary care providers**, **psychiatrists** and **psychiatric nurse practitioners**, and **oral health** providers.
   - An **aging workforce** is a leading factor in the declining supply of providers.

5. **Health Care System Redesign, Including Information Technology**
   - It is a priority of the State to engage health care information technology (IT) in ways that improve care so that it is **patient-centered**, **safe**, **efficient** and **cost-effective**.
6. **Population-based Analysis**
   - Should be used as the **primary methodology** for evaluating the use of health care services, the **allocation** of existing services, the **need** for additional services, and health care **outcomes**.
7. **Integration of Care**
   - There is a need to improve the integration of **primary care and specialty care**, **physical health care and mental health care**, and **mental health care and substance abuse care**.

HRAP Chapters

- Chapter 1: Inpatient, Emergency & Hospital-based Services
- Chapter 2: Ambulatory Care Services
- Chapter 3: Community-based Services
- Chapter 4: Other Medical Services
- Chapter 5: Healthcare Workforce
- Chapter 6: Healthcare Information Technology

Chapter 1: Inpatient, Emergency & Hospital-based Services

HRAP Priorities

- Determining and developing the appropriate amount and distribution of inpatient beds, especially **private beds**, **psychiatric beds**, **rehabilitation beds** and **nursing home beds**.

- Developing **access standards** and using the science of **population-based analysis** can help policymakers determine the appropriate number and distribution of inpatient beds, as well as adequate levels of outpatient services, emergency services, and major medical equipment.

- A key element in containing health care costs and improving outcomes is to invest in **preventive services and effective treatment for chronic illnesses** at the inpatient and outpatient levels.

Chapter 1: Inpatient, Emergency & Hospital-based Services
Quick Facts – Major Medical Equipment

- Statewide, and including Dartmouth-Hitchcock Medical Center, there are:
  - 8 linear accelerators (all fixed)
  - 4 PET scanners (one fixed and three mobile)
  - 17 MRI devices (seven fixed, 10 mobile)
  - 8 catheterization labs (all fixed)
  - 20 CT scanners (all fixed)
  - 7 angiographic systems (all fixed)
- For **PET, MRI and CT, Vermont exceeds U.S. averages** in number of machines per 100,000 population.
- **Over 90% of Vermonters have access to MRIs and CT scans within approximately 30 minutes** of travel and two thirds or more Vermonters have access to linear accelerators, PET scans, cath labs, and a angiographic systems within approximately 60 minutes of travel.

Chapter 1: Inpatient, Emergency & Hospital-based Services
Recommendations - Major Medical Equipment

Recommendation 1. Evaluate disbursement or acquisition of major medical equipment (MME) based on a **population-based utilization analysis, clinical quality, CON criteria and standards, and financial feasibility.** Other factors to consider include the **availability of trained personnel**, and an evaluation of **patient need vs. convenience**, **urgent vs. non-urgent** use, and **single test vs. repetitive tests**.

Recommendation 2. Generally, **introduce major new medical equipment technology first at an academic medical center** serving a significant number of Vermonters.

Chapter 6: Healthcare Information Technology
HRAP Priorities

- A **coordinated healthcare information technology** throughout Vermont's health care system is the overall priority for information technology. A collaborative implementation of appropriate healthcare information technology, especially models for electronic health/patient records, will be key to improving Vermont's health care system, especially in terms of making care more safe, efficient and effective.

Chapter 6: Healthcare Information Technology
Quick Facts – Clinical Information Tools

- Bar-coded medicine administration systems have been demonstrated nationally to be among the easiest and most effective clinical information tools to adopt. The VA's use of a **bar-coded system has yielded an 86% reduction rate in medication errors**. **Thirteen of 14 Vermont hospitals surveyed identified this application as a priority over the next two years**.
- The benefits of EMRs include increased safety, reduced medical errors, improved quality and reduced overhead costs.
- In 2003, approximately 2,000 U.S. hospitals were using some form of **picture archiving and communications system (PACS)**. Six Vermont hospitals currently utilize some type of PACS system: Brattleboro Memorial Hospital, Copley Hospital, Fletcher-Allen Health Care, Mt. Ascutney, Rutland Regional Medical Center, and Southwestern Vermont Medical Center.

Chapter 6: Healthcare Information Technology
Quick Facts – Interoperability

- A US Department of Health and Human Services initiative has identified creating National Health Information Network, which would rely on interoperability of medical systems, as a national healthcare priority over the next 10 years.
- Cost, operator know-how, technological issues and data privacy are the main concerns with implementation of interoperability systems.
- Interoperability would pave the way for a national public health information network for broad dissemination of public health concerns.

- **Standards for Demonstrating Consistency with the Health Resource Allocation Plan (18 V.S.A. §9437(1)):**
- In furtherance of the statutory Certificate of Need criteria in 18 V.S.A. §9437(1), applicants have the burden of demonstrating, by a preponderance of the evidence, that their proposed projects are consistent with the Health Resource Allocation Plan including, but not limited to, the relevant Principles, Recommendations, and CON Standards therein. The Commissioner may determine that one or more Principles, Recommendations, or CON Standards, although relevant, are not material to an applicant's burden of proving its proposed project is consistent with the Health Resource Allocation Plan.

HRAP CON Standards

- **1. The project is needed to meet an identifiable, existing, or reasonably anticipated need and:**

- a. current resources are unable to meet the need,
- b. the project will improve health outcomes,
- c. utilization review procedures will be put in place to ensure appropriate utilization, and
- d. in the absence of the proposed new service, patients would experience serious problems in terms of costs, availability, quality, or accessibility in obtaining care of the type proposed.

- **2. That the proposed health care project will facilitate implementation of the HRAP concerning the resources, needs and appropriate system of delivery of health care services.**
- **3. That the impact of the project on payers, including uninsured persons, insurers, employers, self-insureds, and State, federal and local governmental providers of health care benefits is necessary and reasonable.**

- **4. That the project will help meet the needs of medically underserved groups and the goals of universal access to health services.**

- **5. That the applicant has taken appropriate and reasonable steps, both prior to and in conjunction with development of the proposed project, to discover and implement collaborative approaches, in conformance with State and Federal laws, to meeting the needs identified in the proposal, including collaborating with other similar providers, dissimilar providers and other entities in its service area, in-state region, State, and appropriate regions beyond Vermont.**

- **6. That the proposal will foster implementation of the Vermont Blueprint for Health: Chronic Care Initiative, including the following goals and values:**
- **a. Goals:**
- 1. Vermonters with chronic conditions will be effective managers of their own health.
- 2. The proportion of individuals receiving care consistent with evidence-based standards will increase.
- 3. Vermonters will live in communities that support healthy lifestyles, and have the ability to prevent and manage chronic conditions.
- 4. A chronic care information system (registry functionality) will be available to providers, which will support chronic disease prevention, treatment and management for effective individual and population-based care.
- 5. Vermonters will be served by a health care system that invests in and rewards quality.

- **b. Values:**
- 1. Self-care: empower and prepare patients to manage their health and health care; emphasize the patient's central role in managing their health; use effective self-management support strategies; organize internal and community resources to provide ongoing self-management support to patients.
- 2. Community: mobilize community resources to meet needs of patients.
- 3. Health Care System: create a culture, organization and mechanisms that promote safe, high quality care; visibly support improvement at all levels of the organization; encourage open and systemic handling of errors and quality problems; provide incentives based on quality of care; develop agreements that facilitate care coordination within and across organizations.

- 4. Clinical Information System: organize patient and population data to facilitate efficient and effective care.
  5. Decision Support: promote clinical care that is consistent with scientific evidence and patient preferences: embed evidence-based guidelines into daily clinical practice.
- 6. Delivery System Design: assure the delivery of effective, efficient clinical care and self- management support; define roles and distribute tasks among team members; use planned interactions to support evidence-based care; provide clinical case management services for complex patients; ensure regular follow up by the care team; give care that patients understand and that fits with their cultural background.

7. If a project proposes to, or is likely to, expand geographic access to services, that:

a. the current travel-time exceeds reasonable access standards;
b. the cost to those who finance Vermont's health care system will not increase unreasonably;
c. improvements in clinical outcome or quality of care are demonstrated that outweigh or justify any added cost, and
d. increased costs can, and should be, reasonably absorbed, or funded, by the payers

8. If a project proposes to retain access to one or more services, that:

a. maintaining the current level of access for each service is consistent with meeting the provisions in the Health Resource Allocation Plan;
b. the cost to those who finance Vermont's health care system will not increase unreasonably;
c. improvements in clinical outcome or quality of care are demonstrated that outweigh or justify any added cost, and
d. increased costs can, and should be, reasonably absorbed, or funded, by the payers;

- **9. Generally, that high-technology services new to Vermont are introduced first at tertiary care hospitals serving significant numbers of Vermonters, and that the scientific evidence from peer-reviewed journals or controlled studies will permit definitive conclusions concerning the effectiveness, safety and efficiency of the technology.**
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- a. That protocols for each technology modality will be or have been developed to screen out inappropriate and inefficient use of the modality.
- b. That acquisition of major medical equipment or services is included in the applicant's long-range plan, operating budget and capital budget where appropriate, and is consistent with the statewide targets or budgets adopted by the Department of Banking, Insurance, Securities, and Health Care Administration.

- 10. That, with respect to straight replacement of major medical equipment, existing equipment is fully depreciated, or the cost of early replacement, including the cost of remaining depreciation on the existing equipment, is demonstrated to be less costly.
- 11. That, with respect to radiation therapy:
- a. For any radiation therapy service established outside of a tertiary center, formal linkages will be or have been established for on-going utilization review and quality assessment in collaboration with a tertiary center.
- b. Any proposal for a new linear accelerator unit demonstrates that the accelerator will perform an adequate number of treatments per year, by the second year of operation, based on analyses of state regional and national benchmarks, to achieve sufficient utilization to ensure the additional unit is needed and will perform safely, effectively, and efficiently.

- **12. That, with respect to dialysis for end-stage renal disease:**
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- Kidney dialysis of non-acute patients will be provided only through academic medical centers or applicants providing a comparable quality and continuity of care and serving a significant number of Vermonters, either directly or through a satellite service, for both in-home and in-hospital dialysis, or at other locations providing a comparable quality and continuity of care.

- **13. That, with respect to open-heart surgery and cardiac catheterization:**
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- a. Open-heart surgery will be provided only at Fletcher Allen Health Care, Dartmouth-Hitchcock, and Albany Medical Centers, or other out-of-state facilities qualified and approved by their State authorities to do so.
- b.Cardiac catheterization services will be provided in accordance with the most current recommendations found in the August 1998 Report of the Cardiac Catheterization Work Group to the Division of Health Care Administration prepared by the Vermont Program for Quality in Health Care, or from subsequent such groups.

- **14. That, with respect to magnetic resonance imaging (MRI):**
- a. Fixed MRI capacity will not be increased until current capacity is in excess of valid state, regional and national benchmarks for medically necessary exams per year and sufficient additional need is demonstrated, based on analyses of state, regional and national benchmarks, to demonstrate that another fixed unit will achieve sufficient utilization to ensure the additional unit is needed and will perform safely, effectively and efficiently, and that information on current use documents the effectiveness of internal programs to eliminate unnecessary exams.
- b. Forecasting use of MRI service employs use rates that take into account MRI specific data on use by Vermonters, and that the forecasting method employed is based on best practice and incorporates conservative use assumptions.
- c. The conversion of a mobile service to a site employing a fixed unit will be accomplished without any increase in the costs and charges for the service at the hospital, based on the most current volume of the mobile service.
- d. Prior to approving additional capacity, information on current use is provided that documents the effectiveness of the internal program to eliminate unnecessary exams.

- **15. That, with respect to computed (CT) tomographic scanning:**
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- a. Forecasting use of CT service employs use rates and market share forecasts that take into account actual CT data on use by Vermonters.
- b. The conversion of a mobile service to a site employing a fixed unit will be accomplished without any increase in the costs and charges for the service at the hospital, based on the most current volume of the mobile service.
- c. Prior to approving additional capacity, information on current use and best practice will be provided documenting the effectiveness of the internal program to eliminate unnecessary exams.

- **16. That, with respect to mental health and substance abuse services, the project will:**
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- a. foster the State's focus on developing a coordinated system that encourages access to the appropriate and least restrictive level of care;
- b. reflect the desirability of retaining the designated local provider network for the treatment of individuals with long-term and severe psychiatric needs;
- c. meet or exceed appropriate access and quality standards, including the following:
- 1. Short term psychiatric care (not necessarily in a dedicated unit) and psychiatric emergency care should be available to most Vermonters within the geographic areas served by the designated agency system for mental health, substance abuse and developmental services.

- 2. Psychiatric services in dedicated units should be available to most Vermonters within the hospital service areas for the regional and tertiary hospitals.
- 3. Services should meet the six IOM Aims, with particular focus on achieving patient-centered (and family-centered) and safe care.
- 4. Services should address unmet need in Vermont for:
- i. mental health, psychiatric and substance abuse services, particularly for children and adolescents;
- ii. access to intensive outpatient programs;
- iii. access to partial hospitalization programs;
- iv. improved treatment for suicidal

- v. improved education and support for primary care providers, and better integration of primary care and mental health;
- vi. improved care for people with co-occurring disorders;
- vii. access to opiate addiction treatment (methadone and buprenorphine).
- viii. availability of outpatient services in order to decrease the demand for more costly emergency and hospital-based care
- ix. sufficient mental health and substance abuse prevention, screening and aftercare services;
- x. access to residential care;
- xi. peer recovery services

- xii. suicide prevention programs,
- xiii. a full range of community-based treatment and support,
- xiv. affordable housing options,
- xv. substance abuse primary prevention efforts,
- xvi. safe and sober housing for people in recovery,
- xvii. increased peer-operated programs for mental health recovery.
- xviii. diversion programs such as use of the 72-hour emergency hold programs and other initiatives in psychiatric units in the State's local general hospitals as effective tools in diverting admissions from the Vermont State Hospital or its successor facilities.
- xix. adjustments to the available beds at VSH or its successors made in accordance with the capacity of community programs to provide effective services.
- xx. maintaining current levels of local capacity and also supporting necessary increases in existing facilities.

- xxi. additional beds in community hospitals, to be measured on a case-by-case basis.
- xxii. capacity in therapeutic community residences to be kept at levels adequate to assure maintenance of the census at Vermont State Hospital and its successor institutions at appropriate levels.
- xxiii. organizations providing mental-health services to have linkage agreements with other appropriate providers in the community to assure a coordinated system of care that allows access to the appropriate level of care.

- **17. A proposal to establish an Ambulatory Surgical Center shall not be approved unless the applicant demonstrates that:**
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- a. the procedures performed in the facility will be limited to those procedures that are not anticipated to require an overnight stay and that can be performed safely in such a center;
- b. in order to ensure safety for patients who experience complications requiring transfer to a general hospital, the facility must be located within appropriate travel time to one or more licensed general hospitals where there are three or more operating rooms;
- c. the facility will provide services for post-operative complications and inquiries by ambulatory surgical center patients on a 24-hour basis;
- d. Demonstrate how the applicant will provide access to all residents of each community within the identified service area(s) without regard to individuals' payer type, insurance status or ability to pay for needed services.

- e. the proposed facility will make the following assurances that if the ASC is approved it will:
- 1. secure and maintain Medicare certification, when appropriate (accreditation by other organizations is encouraged);
- 2. comply with the access requirements of § 504 of the Rehabilitation Act and those of the Americans with Disabilities Act;
- 3. develop and maintain a transfer agreement with at least one nearby hospital, as well as a transport agreement with an EMS service for its emergency transport requirements;
- 4. ensure that all staff are well qualified, and that the clinical personnel are eligible for --- or have privileges for --- similar surgical procedures at a local hospital;
- 5. report utilization data in a form consistent with the data provided by hospitals to the Division of Health Care Administration for similar ambulatory surgery cases; and,
- 6. institute a quality review system, and cooperate with all public and private review organizations: and demonstrate that it will institute best practices protocols.

- **18. That, with respect to nursing home care:**
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- a. the applicant provide a written recommendation from the Agency of Human Services regarding plans to increase, reduce, or reconfigure the supply of nursing home beds,
- b. the applicant provide the Department with the nursing home bed need determinations by the Department of Aging and Independent Living, which determinations will be regarded as persuasive and will be presumed as the best evidence available,
- c. the applicant demonstrate the need for additional capacity to meet nursing home level of care, including documenting the options for developing additional community-based services including Medicaid waiver services, residential alternatives, and adult day programs,
- d. the applicant demonstrate, in order to serve the State's goals of reducing expenditures for nursing home services and enhancing funding for non-institutional services, that its proposal complies with the Agency of Human Services' (AHS) initiatives with individual institutions to reallocate resources in an orderly manner while reducing the supply of nursing home beds.

- **19. That the applicant demonstrate, in a proposal to add swing beds, that:**
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- a. The applicant has adequately explained why it is appropriate for a long-term patient requiring custodial services to be served in a swing bed despite the fact hospitals cannot normally afford to replicate the services commonly delivered in a nursing home, or other long-term care facility if appropriate, at a reasonable cost;
- b. The size and the staffing of the swing bed unit and the diagnoses of the patients being served will not negatively and unreasonably affect the costs of the service and the types of patients that may be served appropriately;
- c. Any further increases in the swing bed supply will take into account:
- 1. Potential effects on the State Medicaid budget.
- 2. Continuity of care for patients.
- 3. Additional costs incurred in caring for patients.
- 4. Appropriate environment for patients requiring short-term but clinically intensive oversight and/or treatment

- **20. That, with respect to applications for new home health agencies:**
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- a. the applicant demonstrates that the addition of such agencies is necessary and reasonable, particularly in light of the data collected by the Department to monitor access to services provided through the currently-certified home health agencies and evidence provided by the applicant, interested parties, competing applicants, amicus curiae and members of the public;
- b. the applicant demonstrates the financial impacts of the proposed project relevant to the provision of home health care and the State's goal of attaining universal access to such care are necessary and reasonable; and
- c. the applicant demonstrates how it will provide access to all residents of each community within the identified service area(s) without regard to individuals' payer type, insurance status or ability to pay for needed services.
- d. The impact of proposed new services on continued access to the existing continuum of services within each service area should be considered. Adverse impact on the continued accessibility of the full continuum of services should be avoided.

- **21. That, in the case of construction projects, both new and renovation:**
-
- a. the costs and methods of the proposed construction, including the costs and methods of energy provision and the probable impact of the construction project on the cost of providing health services are necessary and reasonable;
- b. the project is cost-effective in terms of energy conservation measures;
- c. the impact of construction on the cost of new services is necessary and reasonable;
- d. in the case of new construction, that it is the best alternative; and
- e. the construction project will comply with the Guidelines for Construction and Equipment of Hospital and Medical Facilities as issued by the American Institute of Architects (AIA), Committee on Architecture for Health that the applicant will comply with the terms of Section 504 of the Rehabilitation Act of 1973, related to handicapped access, and that the applicant will comply with the standards for commercial construction, assuring nondiscrimination on the basis of disability

- **22. For hospitals subject to budget review, that the proposed health care project's impact on the hospital's established budget(s) and the unified health care budget is necessary and reasonable.**
- **23. That, the following services, primarily found in hospitals, are considered appropriate services to be provided in the following categories of hospitals:**

- **a. Critical Access, Community, Regional, or Tertiary Hospitals in Vermont:**
- **1. Low-risk maternity care (including nursery)**
- **2. General inpatient medical/surgical care**
- **3. General intensive care**
- **4. Pediatric care (not necessarily in a dedicated unit)**
- **5. Short-term psychiatric care (not necessarily in a dedicated unit)**
- **6. Routine imaging service (x-ray, radiographic, fluoroscopic, ultrasound, mammography, basic nuclear medicine and CT scanning)**

- 7. Therapies (physical, speech, occupational and nutritional) Emergency care, including stabilizing major trauma cases before transfer and including psychiatric emergencies
- 8. Ambulatory surgery
- 9. Psychiatric services in dedicated units
- 10. Magnetic resonance imaging
- 11. Medical rehabilitation services in dedicated units
- 12. Renal dialysis

b. Tertiary Hospitals in Vermont:

- 1. Kidney transplantation
- 2. Major trauma treatment
  - (massive head and or chest trauma)
- 3. Neonatal intensive care
- 4. Open-heart surgery

- c. Hospitals outside Vermont providing specialized services:
- 1. Experimental procedures
  - (unless 100% supported by grant funds)
- 2. Major burn care
- 3. Organ transplantation
  - (other than kidney or kidney/pancreas)
- 4. Specialty pediatric care (e.g., open-heart surgery)

HRAP Next Steps

- Identify, define, and adopt guidelines and methodologies to ensure valid **population-based analysis**
- Define hospital **service areas**, community service areas, and other health care service areas
- Identify and define **geographic access standards**
- Identify and define **utilization benchmarks**
- Promote outreach, health promotion, health screening, prevention, and chronic care efforts
- Support additional research on **evidence-based practices**, quality improvement and performance standard

HRAP Next Steps

- Support ongoing efforts by the industry to assess **workforce needs**; address shortages
- Monitor the need for, and, where appropriate, support the improvement of **information technology** across all settings.
- Support improved **integration of primary care with mental health and substance abuse care**.
- Engage in **administrative rulemaking** where applicable, including adopting procedural guidelines for CON.